WHOSE *Records to be Disclosed*	
NAME First Middle Last	
SSN	**Birthday (mm/dd/yyyy)**
ARG USE ONLY NUMBER HOLDER (if other than above) **NAME** **SSN**	

AUTHORIZATION TO DISCLOSE INFORMATION TO ARBOR E&T, LLC ACTION REVIEW GROUP (ARG)

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to: -Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501) -Drug abuse, alcoholism, or other substance abuse -Sickle cell anemia -Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases -Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluation.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by ARG
- Employers
- Others who may know about my condition
- (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY ARG (as needed). Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed.

TO WHOM **The State contractor authorized to process my case including contract copy services, and doctors or other professionals consulted during the process.**

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to ARG and my sources to revoke this authorization at any time (see page 2 for details).
- ARG will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

INDIVIDUAL authorizing disclosure **SIGN** ▶	IF not signed by subject of disclosure, specify basis for authority to sign ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain) (Parent/guardian sign here if two signatures required by State law) ▶
Date Signed	**Street Address**
Phone Number	**City** / **State** / **Zip**

WITNESS *I know the person signing this form or am satisfied of this person's identity:* **SIGN** ▶	**IF** needed, second witness sign here (e.g., if signed with "X" above) **SIGN** ▶
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

EXPLANATION OF FORM MEDICAL RELEASE 2 "AUTHORIZATION TO DISCLOSE INFORMATION TO ARBOR E&T, LLC ACTION REVIEW GROUP (ARG)"

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form ARG Release 2. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source, and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to ARG. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; ARG can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by ARG to decide your claim.

It is ARG's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. ARG makes every reasonable effort to ensure that the information in the ARG Release 2 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by ARG is protected by the Privacy Act of 1974. Under a Business Associates Agreement with the State of Colorado (HCPF), your private health information is protected and will not be used for any purpose other than to make a medical disability determination. Your personal health information remains protected under the health information privacy provisions of 45 CFR 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA)). After a medical determination is made and the necessary waiting period for appeal purposes has passed, all medical information is sent to the county where you applied. Once the medical information is returned to the county, it will be destroyed in order to protect your personal health information.

ARG is authorized to collect the information on form ARG Release 2 by sections 205(a), 223 (d)(5)(A), 1614(a)(3)(H)(i), 163(d)(1) and 1631 (3)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in ARG. In some cases, your information may also be reviewed by Administrative Law Judges and by Health Care Policy and Financing (HCPF) personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. The information we obtain with this form will only be used for the purpose of determining eligibility for Medicaid. The only two instances where your information will be released will be:

1. To enable a third party (e.g. consulting physicians) or other government agency to assist ARG to determine eligibility to for Medicaid.
2. To provide necessary medical information for the purpose of consulting examinations. Other than the above limited circumstance, ARG will not redisclose any medical information without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Agencies may use matching programs only to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from ARG or HCPF.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO: Arbor E & T, Action Review Group, PO Box 340, Olyphant, PA 18447. You may FAX it to ARG at 1-877-672-2077. You may call ARG at 1-877-265-1864. Email: actionreviewgroupmrt@arboret.com.**